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# PAULA ACKER L.C.S.W INTAKE FORM

Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Age \_\_\_\_\_

Gender:  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Insurance Information Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Marital Status \_\_\_\_\_

Name of Spouse/Partner \_\_\_\_\_

How Long Have Both of You Been Together? \_\_\_\_\_

Religion \_\_\_\_\_

If Client is a Minor, Name of Responsible

Adult \_\_\_\_\_

Phone Contact \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

*There are times when prior medical and psychological records will be requested.  
Please make sure that all information given below is correct.*

Do You Smoke? \_\_\_\_\_ How Much? \_\_\_\_\_

Do You Drink? \_\_\_\_\_ How Much? \_\_\_\_\_

Do You Take Drugs? \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

How often? \_\_\_\_\_

Last Medical Examination \_\_\_\_\_

Are you now under a doctor's care? \_\_\_\_\_

If yes, Doctor's name: \_\_\_\_\_

Reason for Doctor's

care: \_\_\_\_\_

\_\_\_\_\_

Are You Taking Any Medication? \_\_\_\_\_ If yes, what

kind? \_\_\_\_\_

Reason for

Medication: \_\_\_\_\_

Have You Ever Been Hospitalized for a Physical

Illness? Describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc?

Describe: \_\_\_\_\_

\_\_\_\_\_

Any Previous Therapy/Counseling? \_\_\_\_\_ If Yes, Name and Phone Numbers of

Therapists: \_\_\_\_\_

\_\_\_\_\_

When and Number of

Sessions: \_\_\_\_\_

Type of Therapy/Counseling: \_\_\_\_\_

How were you referred to Paula Acker L.C.S.W? \_\_\_\_\_

What do you Wish to Achieve with

Therapy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Check Any of the Following That May Apply to You:**

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Inferiority Feelings	<input type="checkbox"/>	Shy With People
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Feel Tense	<input type="checkbox"/>	Can't Make Friends
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Feel Panicky	<input type="checkbox"/>	Afraid Of People
<input type="checkbox"/>	No Appetite	<input type="checkbox"/>	Fears and Phobias	<input type="checkbox"/>	Home Conditions Bad
<input type="checkbox"/>	Over-Eating	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>	Unable To Have A Good Time
<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Always Worried About Something
<input type="checkbox"/>	Bowel Disturbances	<input type="checkbox"/>	Suicidal Ideas	<input type="checkbox"/>	Don't Like Weekends/Vacations
<input type="checkbox"/>	Always Tired	<input type="checkbox"/>	Dangerous Drugs	<input type="checkbox"/>	Can't Make Decisions
<input type="checkbox"/>	Unable To Relax	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Financial Problems
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	Recurrent Dreams	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Job Problems

Signature \_\_\_\_\_ Date \_\_\_\_\_